State of New Jersey
Department of the Treasury
Division of Pensions and Benefits

EMPLOYEE DENTAL PLANS

MEMBER HANDBOOK

THE DENTAL PLAN ORGANIZATIONS
AND
THE DENTAL EXPENSE PLAN

For Members of the
State Health Benefits Program
and
School Employees' Health Benefits Program

Plan Year 2013

BLANK PAGE

TABLE OF CONTENTS

SECTION THREE

SECTION FOUR

BLANK PAGE

INTRODUCTION

The State Health Benefits Program (SHBP) was established in 1961. It offers medical and prescription drug coverage to qualified State and local government public employees, retirees, and eligible dependents; and dental coverage to qualified State and local government/education public employees, retirees, and their eligible dependents. Local employers must adopt a resolution to participate in the SHBP.

The State Health Benefits Commission (SHBC) is the executive organization responsible for overseeing the SHBP.

The State Health Benefits Program Act is found in the New Jersey Statutes Annotated, Title 52, Article 14-17.25 et seq. Rules governing the operation and administration of the program are found in Title 17, Chapter 9 of the New Jersey Administrative Code.

The School Employees' Health Benefits Program (SEHBP) was established in 2007. It offers medical and prescription drug coverage to qualified local education public employees, retirees, and eligible dependents. Local education employers must adopt a resolution to participate in the SEHBP.

The School Employees' Health Benefits Commission (SEHBC) is the executive organization responsible for overseeing the SEHBP.

The School Employees' Health Benefits Program Act is found in the New Jersey Statutes Annotated, Title 52, Article 14-17.46 et seq. Rules governing the operation and administration of the program are found in Title 17, Chapter 9 of the New Jersey Administrative Code.

The Division of Pensions and Benefits, specifically the Health Benefits Bureau and the Bureau of Policy and Planning, are responsible for the daily administrative activities of the SHBP and the SEHBP.

The Employee Dental Plans consist of the Dental Plan Organizations and the Dental Expense Plan. The Employee Dental Plans are available to full-time employees of the State of New Jersey, State colleges and universities, certain independent State agencies, and adopting local government and local education employers. Before making any enrollment decision, you should carefully review the standards of eligibility and the conditions, limitations, and exclusions of the benefit coverage offered under each plan. The complete terms of Employee Dental Plans coverage are described in the Dental Plan Organization and Dental Expense Plan contracts with amendments.

Every effort has been made to ensure the accuracy of the *Employee Dental Plans Member Handbook*. However, State law and the New Jersey Administrative Code govern the SHBP and SEHBP. If there are discrepancies between the information presented in this booklet and/or plan documents and the law, regulations, or contracts, the law, regulations, and contracts will govern. Furthermore, if you are unsure whether a dental service or procedure is covered, contact your dental plan before you receive services to avoid any denial of coverage issues that could result.

If, after reading this booklet, you have any questions, comments, or suggestions regarding the information presented, please write to the Division of Pensions and Benefits, PO Box 295, Trenton, NJ 08625-0295, call us at (609) 292-7524, or send e-mail to: *pensions.nj@treas.state.nj.us*

SECTION ONE

EMPLOYEE DENTAL PLANS ELIGIBILITY

Eligibility for coverage is determined under the provisions of the State Health Benefits Program (SHBP). Enrollments, terminations, changes to coverage, etc. must be presented through your employer to the Health Benefits Bureau of the Division of Pensions and Benefits.

If you have any questions concerning eligibility provisions, you should see your employer's benefits administrator. You can also contact the Division of Pensions and Benefits, Office of Client Services at (609) 292-7524 or by e-mail at: *pensions.nj@treas.state.nj.us*

STATE EMPLOYEES

To be eligible for State Employee coverage, you must work full-time for the State of New Jersey or be an appointed or an elected officer of the State of New Jersey (this includes employees of a State agency or authority and employees of a State college or university). For State employees, full-time requires 35 hours per week or more if required by contract or resolution.

State part-time employees covered under Chapter 172, P.L. 2003, and State intermittent employees covered by negotiated agreements between the State of New Jersey and the Communications Workers of America (CWA) are not eligible for coverage under the Employee Dental Plans.

LOCAL EMPLOYEES

To be eligible for Employee Dental Plans local employer coverage, you must be a full-time employee or an appointed or elected officer receiving a salary from a local government/education employer (county, municipality, county or municipal authority, board of education, etc.) that participates in the SHBP and/or the School Employees' Health Benefits Program (SEHBP) and has adopted a resolution to provide dental benefits under the Employee Dental Plans.

Each participating local employer defines, in its resolution, the minimum hours required to be considered a full-time employee, but it can be no less than 25 hours per week or more if required by contract. Employment must also be for 12 months per year except for employees whose usual work schedule is 10 months per year (the standard school year).

Local part-time employees covered under Chapter 172, P.L. 2003, are not eligible for coverage under the Employee Dental Plans.

ELIGIBLE DEPENDENTS

Your eligible dependents are your spouse, civil union partner, or eligible same-sex domestic partner (as defined on page 3) and/or your eligible children (as defined on page 3).

Spouse — A member of the opposite sex to whom you are legally married. A photocopy of the marriage certificate and additional supporting documentation are required for enrollment.

Civil Union Partner — A person of the same sex with whom you have entered into a civil union. A photocopy of the *New Jersey Civil Union Certificate* or a valid certification from another jurisdiction that recognizes same-sex civil unions and additional supporting documentation are required for enrollment. The cost of civil union partner coverage may be subject to federal tax (see your employer or Fact Sheet #75, *Civil Unions,* for details).

Domestic Partner — A person of the same sex with whom you have entered into a domestic partnership as defined under Chapter 246, P.L. 2003, the Domestic Partnership Act. The domestic partner of any State employee, State retiree, or an eligible employee or retiree of a participating local public entity that adopts a resolution to provide Chapter 246 health benefits, is eligible for coverage. A photocopy of the *New Jersey Certificate of Domestic Partnership* dated prior to February 19, 2007 (or a valid certification from another State or foreign jurisdiction that recognizes same-sex domestic partners) and additional supporting documentation are required for enrollment. The cost of same-sex domestic partner coverage may be subject to federal tax (see your employer or Fact Sheet #71, *Benefits Under the Domestic Partnership Act,* for details).

Children — In compliance with the federal Patient Protection and Affordable Care Act (PPACA), coverage is extended for children until age 26. This includes natural children under age 26 regardless of the child's marital, student, or financial dependency status. A photocopy of the child's birth certificate* that includes the covered parent's name is required for enrollment.

Stepchildren, foster children, legally adopted children, and children in a guardian-ward relationship under age 26 are also eligible. A photocopy of the child's birth certificate, **and** additional supporting legal documentation are required with enrollment forms for these cases. Documents must attest to the legal guardianship by the covered employee.

Coverage for an enrolled child ends on December 31 of the year in which the child turns age 26 (see the "COBRA" section on page 4 and "Dependent Children with Disabilities" below for continuation of coverage provisions).

Please Note: There is <u>no</u> provision for dental coverage under Chapter 375, P.L. 2005 which provides medical and/or prescription drug coverage to over age children until age 31.

Dependent Children with Disabilities — If a child is not capable of self-support when he or she reaches age 26 due to mental illness, mental retardation, or a physical disability, he or she may be eligible for a continuance of coverage. To request continued coverage, contact the Office of Client Services at (609) 292-7524 or write to the Division of Pensions and Benefits, Health Benefits Bureau, 50 West State Street, P. O. Box 299, Trenton, New Jersey 08625 for a *Continuance for Dependent with Disabilities* form. The form and proof of the child's condition must be given to the Division no later than 31 days after the date coverage would normally end. Since coverage for children ends on December 31 of the year they turn 26, you have until January 31 to file the *Continuance for Dependent with Disabilities* form. Coverage for children with disabilities may continue only while (1) you are covered through the SHBP or SEHBP, and (2) the child continues to be disabled, and (3) the child is unmarried, and (4) the child remains dependent on you for support and maintenance and lives with you. You will be contacted periodically to verify that the child remains eligible for continued coverage.

---

*Or a *National Medical Support Notice* (NMSN) if you are the non-custodial parent and are legally required to provide coverage for the child as a result of the NMSN.

RETIREES

The Employee Dental Plans are not available to retirees. At retirement, retirees who are eligible for enrollment into the Retired Group of the SHBP or SEHBP may elect to enroll for coverage in the **Retiree Dental Expense Plan.**

Note: Employees who at retirement are eligible to enroll in the Retired Group of the SHBP or SEHBP cannot continue Employee Dental Plan coverage under COBRA (see below).

For more information about the Retiree Dental Expense Plan, see Fact Sheet #73, *Retiree Dental Expense Plan,* or the *Retiree Dental Expense Plan Member Handbook* (see page 50 for information on how to obtain these publications).

COBRA COVERAGE

CONTINUING COVERAGE WHEN IT WOULD NORMALLY END

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federally regulated law that gives employees and their eligible dependents the opportunity to remain in their employer's group coverage when they would otherwise lose coverage. COBRA coverage is available for limited time periods and the member must pay the full cost of the coverage plus an administrative fee.

Under COBRA, you may elect to continue in any or all of the coverages you had as an active employee or dependent (health, prescription drug, dental, and vision). You may also change your health or dental plan when enrolling in COBRA. You may elect to cover the same dependents that you covered while an active employee, or delete dependents from coverage — however, you cannot add dependents who were not covered while an employee except during the annual Open Enrollment period or unless a "qualifying event" (marriage, birth or adoption of a child, etc.) occurs within 60 days of the COBRA event.

The rules and plan provisions that govern COBRA coverage for the Employee Dental Plans are the same as those for the SHBP/SEHBP medical plans. Please refer to the *Summary Program Description* for additional information about your rights and responsibilities under COBRA (see page 50 for information on how to obtain this publication).

Note: Employees who at retirement are eligible to enroll for coverage in the Retired Group of the SHBP or SEHBP cannot enroll for health benefits coverage under COBRA.

SECTION TWO

EMPLOYEE DENTAL PLANS

All benefits listed in this handbook may be subject to limitations and exclusions as described in subsequent sections.

Even though a service or supply may not be described or listed in this handbook, that does not make the service or supply eligible for a benefit under this plan.

GENERAL CONDITIONS OF THE DENTAL PLANS

ENROLLMENT

Enrollment in a dental plan is optional. If you do not enroll when first eligible, you will have the option to enroll each year during the annual SHBP/SEHBP Open Enrollment Period.

In deciding whether to enroll and which plan to choose, you should consider the differences in out-of-pocket costs, the covered services between a Dental Plan Organization and the Dental Expense Plan, and the degree of flexibility that you may want in selecting a dentist.

Eligibility for coverage is determined under the provisions of the SHBP. Enrollments, terminations, changes to coverage, etc. must be presented through your employer to the Health Benefits Bureau of the Division of Pensions and Benefits.

Limitation on Changing Dental Plans

If you choose to enroll in a dental plan, **you must remain in the dental plan you select for at least 12 months.**

Dual Dental Enrollment is Prohibited

SHBP regulations prohibit two members who are married to each other, civil union parthers, or eligible same-sex domestic partners, and who are both enrolled in the SHBP or SEHBP from enrolling under more than one of the dental plans. An individual may belong to a dental plan as an employee or as a dependent but not as both. Furthermore, two SHBP and/or SEHBP members cannot both cover the same children as dependents under their dental plan coverage.

In cases of divorce or single parent coverage of dependents, there is no coordination of benefits under two dental plans.

Other Enrollment Information

Except as indicated above, the rules for enrollment and information on maintaining coverage in the Employee Dental Plans are the same as those for the SHBP/SEHBP medical plans. Please refer to the *Summary Program Description* for additional information about enrollment, dates of coverage, and other coverage provisions under the SHBP and SEHBP.

DENTAL PLAN CHOICES

You may choose to enroll in one of two different types of dental plans:

- The **Dental Plan Organizations** (DPOs) are companies that contract with a network of providers for dental services. There are several DPOs participating in the Employee Dental Plans from which you may choose. You must use providers participating with the DPO you select to receive coverage. Be sure you confirm that the dentist or dental facility you select is taking new patients and participates with the Employee Dental Plans, since DPOs also service other organizations.
- The **Dental Expense Plan** is a traditional indemnity plan that allows you to obtain services from any dentist. After you satisfy the $50 annual deductible (the deductible applies to non-preventive services only), you are reimbursed a percentage of the reasonable and customary charges for the services that are covered under the Dental Expense Plan. This plan is administered under a contract between the State Health Benefits Commission (SHBC) and Aetna Life Insurance Company (Aetna).

LEVELS OF COVERAGE

There are four levels of coverage:

- **Single:** covers the employee only
- **Member and Spouse/Partner*:** covers the employee and his or her spouse, civil union partner, or eligible domestic partner*.
- **Parent and Child(ren):** covers the employee and all enrolled eligible children
- **Family:** covers employee, spouse or partner*, and all enrolled eligible children.

*See page 3 for the definition of a civil union partner or eligible domestic partner.

DENTAL PLAN PREMIUMS

The cost for participation in a dental plan is shared by the State or local employer and dental plan participants. For a current list of premium rates and payroll deduction schedules, please see your benefits administrator.

State Employees

For State employees paid through the State's Centralized Payroll Unit, premium payments are made through biweekly payroll deductions.

For all other State employees, premium payments are made through a deduction schedule determined by your employer.

State employee premiums can be paid on a pre-tax basis through participation in the Premium Option Plan (POP) of the State's IRC Section 125 Program, *Tax$ave.* Participation in POP is automatic unless you specifically decline enrollment. See "Appendix IV" on page 41 for more information on *Tax$ave.*

Note: *Tax$ave* POP members are not permitted to drop coverage within a calendar year unless a qualifying event occurs, see "Appendix IV" on page 41.

Local Government and Local Education Employees

For local employees, premium payments are made through a deduction schedule determined by your employer.

Note: The State *Tax$ave* program is not available to local employees. Contact your employer to find out if you are eligible to pay premiums on a pre-tax basis through an IRC Section 125 Program offered by your employer.

EXTENSION OF COVERAGE PROVISIONS

If Eligibility Ends While Undergoing Treatment

For both **Dental Plan Organizations** and **Dental Expense Plan:**

If coverage for you or a dependent is terminated, the coverage will be extended for 30 days following the end of the coverage in order to complete the following procedures:

- An appliance or modification of an appliance for which the impression was taken while the person was covered.
- A crown or restoration for which a tooth was prepared while the person was covered.
- Root canal therapy for which the pulp chamber was opened while the person was covered.

If DPO Participation is Terminated

If your DPO is no longer offered by the Employee Dental Plans, you will be given the opportunity to join another dental plan provided by the Employee Dental Plans. For services that have already begun prior to plan termination, including a full course of orthodontic treatment, coverage for those services for you and your dependents will be extended at no additional cost to you except for the remaining portion of any copayment that has not yet been paid.

Continuation Under COBRA

See page 4 for additional continuation of coverage provisions available under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

SPECIAL PROVISIONS OF THE EMPLOYEE DENTAL PLANS

COORDINATION OF BENEFITS WITH OTHER INSURANCE PLANS

There is no coordination of benefits between two SHBP dental plans because no individual is eligible for coverage in more than one dental plan.

If you and your dependents are also covered for dental expenses by other plans, certain rules apply that determine which plan provides the primary coverage and how much each plan will reimburse you. The purpose of these rules is to prevent a combined reimbursement from both plans that exceeds the expenses that you actually incur. Although there may be special cases not described here, the usual determination of which plan provides primary coverage is as follows:

- The employee's primary dental coverage is provided by the Dental Expense Plan or the Dental Plan Organization.
- If your spouse/partner is enrolled as your dependent and is also covered by a dental plan through his or her employer, your spouse/partner's primary coverage is through the dental plan offered by his or her employer.
- If your children are enrolled as dependents in your plan and your spouse/partner's plan, their primary coverage is provided by the dental plan of the parent whose birthday falls earlier in the year. If your spouse/partner's plan does not follow this rule, then the rule in the other program will determine the order of benefits.
- In the case of a separation, divorce, dissolution of a civil union or domestic partnership, or parents who are not married, the primary coverage for a child is provided in this order: by the plan of the parent who is legally responsible for the dental expenses of the child; by the plan of the parent with custody of the child; by the plan of the spouse/partner of the parent with custody of the child; or by the plan of the non-custodial parent.

THIRD PARTY LIABILITY

Repayment Agreement

If you have received benefits from your dental plan for services that are either auto-related or work-related, the Employee Dental Plans has the right to recover those payments. This means that if your dental expenses are also reimbursed by a third party through a settlement, satisfied by a judgement, or other means, you are required to return any benefits paid for illness or injury to the Employee Dental Plans. The repayment will only be equal to the amount paid by the Employee Dental Plans.

This provision is binding whether the payment received from the third party is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, whether or not the third party has admitted liability for the payment.

Recovery Right

You are required to cooperate with the Employee Dental Plans in recovering any benefits paid by the plan that may also be payable by a third party. The Employee Dental Plans may:

- Assume your right to receive payment for benefits from the third party;
- Require you to provide all information and sign and return all documents necessary to exercise the Employee Dental Plans' rights under this provision, before any benefits are provided under your group's policy; or
- Require you to give testimony, answer interrogatories, attend depositions, and comply with all legal actions which the Employee Dental Plans may find necessary to recover money from all sources when a third party may be responsible for damages or injuries.

HIPAA PRIVACY

The SHBP and SEHBP make every effort to safeguard the health information of its members and comply with the privacy provisions of the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996. HIPAA requires medical and dental plans to maintain the privacy of any personal information relating to its members' physical or mental health. See "Appendix V" on page 44 for the SHBP/SEHBP's *Notice of Privacy Practices.*

AUDIT OF DEPENDENT COVERAGE

Periodically the Division of Pensions and Benefits preforms an audit using a random sample of members to determine if enrolled dependents are eligible under plan provisions. Proof of dependency such as a marriage, civil union, or birth certificates, or tax returns are required. Coverage for ineligible dependents will be terminated. Failure to respond to the audit will result in the termination of ALL coverage and may include financial restitution for claims paid. Members who are found to have intentionally enrolled an ineligible person for coverage will be prosecuted to the fullest extent of the law.

HEALTH CARE FRAUD

Health care fraud is an intentional deception or misrepresentation that results in an unauthorized benefit to a member or to some other person. Any individual who willfully and knowingly engages in an activity intended to defraud the SHBP or SEHBP will face disciplinary action that could include termination of employment and may result in prosecution. Any member who receives monies fraudulently from a health plan will be required to fully reimburse the plan.

SECTION THREE

THE DENTAL PLAN ORGANIZATIONS

A Dental Plan Organization (DPO) is similar to a medical Health Maintenance Organization (HMO) program. The full cost for most services is prepaid to your dentist, but certain services require an additional copayment from you. Also, if you choose a more expensive treatment than deemed appropriate by your dental provider, you must pay the extra cost. Further, you will not be covered for services if you go to a dentist who is not a member of your DPO, *unless* you are referred by your DPO dentist. There are several Dental Plan Organizations included among the State dental plans (see page 40). Among these organizations, there are two types of plans – Dental Center and Individual Practice Associations (IPA).

- **Dental Centers** employ a group of dentists and technicians who are located at a central office. In a Dental Center Plan, you do not have the option to select a particular dentist unless permitted by the Dental Center. However, some DPOs offer both a Dental Center and a list of participating dentists, thereby giving you the option of selecting a center or a particular dentist.
- **Individual Practice Associations** (IPA) consists of a network of participating dentists who work in their own offices. If you choose an IPA, you must select a specific dentist in the IPA who will treat you and your dependents.

The DPO dentist is responsible for providing all of the services that are listed as covered in this booklet. If the participating dentist that you have selected does not provide a specific service, then the DPO must refer you to another participating dentist located within 10 miles of your dentist's office (or 20 miles for orthodontic service). If you agree, the DPO may also refer you to a dentist located beyond these limits.

If the DPO has no participating dentist who can provide the service in your geographical area, the DPO must refer you to a nonparticipating dentist within the 10 or 20-mile limit. If there is no dentist within this area, you must be referred to the dentist closest to your dentist's office.

If the DPO dentist refers you to another dentist and that referral is approved by the DPO, you will have the same coverage for the service as if you had been treated by your dentist. However, if you select an outside dentist on your own, the service will not be covered.

CONSIDERATIONS IN CHOOSING A DPO

- Obtain a list of DPOs and participating dentists from your benefits administrator. If you choose a dentist rather than a Dental Center, check with the DPO and the dentist to be sure that the dentist is a member of the DPO, services members of the Employee Dental Plans, and will accept you as a new patient.
- If you choose a dentist, you should also check with the dentist to make sure that he or she plans to stay in the DPO. If the dentist leaves, you will have to select another dentist who participates with that DPO.

- You should also check to determine that the DPO dentist or center can serve the needs of your entire family and whether the days and hours of operation are convenient for you and your family.
- If your dentist leaves the DPO, and there are no other dentists in the DPO within 30 miles of your home, you may switch to another dental plan (either another DPO or the Dental Expense Plan).

COVERED SERVICES

The following is a list of covered services and, if applicable, required copayments. Copayments are your portion of the cost for the service.

Codes	Description of Covered Services	Copayments
D0100-D0999	**I. DIAGNOSTIC**	
Clinical Oral Evaluations		
(Oral evaluations are limited to two in a calendar year. Emergency or limited oral evaluations are covered, limited to one evaluation per patient, per dentist, per calendar year. There are no copayments for diagnostic services.)		
D0120	Periodic Oral Evaluation	$ 0
D0140	Limited Oral Evaluation — Problem Focused	$ 0
D0145	Oral Evaluation for Patient Under 3 Years of Age and Counseling with Primary Caregiver	$ 0
D0150	Comprehensive Oral Evaluation — New or Established Patient	$ 0
D0160	Detailed and Extensive Oral Evaluation — Problem Focused, by Report	$ 0
Radiographs		
(Bitewing X-rays are limited to two series of up to 4 films in a calendar year; set of full mouth X-rays are limited to once per 36 month interval; no more than 18 films per set of mouth X-rays)		
D0210	Intraoral — Complete Series of Radiographic Images	$ 0
D0220	Intraoral — Periapical — First Radiographic Image	$ 0
D0230	Intraoral — Periapical — Each Additional Radiographic Image	$ 0
D0240	Intraoral — Occlusal Radiographic Image	$ 0
D0250	Extraoral — First Radiographic Image	$ 0
D0260	Extraoral — Each Additional Radiographic Image	$ 0
D0270	Bitewings — Single Radiographic Image	$ 0
D0272	Bitewings — Two Radiographic Images	$ 0
D0273	Bitewings — Three Radiographic Images	$ 0
D0274	Bitewings — Four Radiographic Images	$ 0
D0277	Vertical Bitewings — Seven to Eight Radiographic Images	$ 0
D0290	Posterior — Anterior or Lateral Skull and Facial Bone Survey Radiographic Image	$ 0
D0330	Panoramic Radiographic Image	$ 0
D0340	Cephalometric Radiographic Image	$ 0
D0391	Interpretation of Diagnostic Image by a Practitioner Not Associated with the Capture of the Image, Including Report	$ 0

Tests and Laboratory Examinations

D0415	Collection of Microorganisms for Culture and Sensitivity	$ 0
D0416	Viral Culture	$ 0
D0421	Genetic Test for Susceptibility to Oral Diseases	$ 0
D0425	Caries Susceptibility Tests	$ 0
D0460	Pulp Vitality Tests	$ 0
D0470	Diagnostic Casts	$ 0

D1000-D1999 II. PREVENTIVE

Dental Prophylaxis

(Limited to two in a calendar year)

D1110	Prophylaxis — Adult	$ 0
D1120	Prophylaxis — Child	$ 0

Topical Fluoride Treatment *(Office Procedure)*

(Limited to two in a calendar year, and only for eligible dependent children under the age of 19 years)

D1203	Topical Application of Flouride (Prophylaxis Not Included) — Child	$ 0
D1204	Topical Application of Flouride (Prophylaxis Not Included) — Adult	$ 0
D1206	Topical Application of Flouride Varnish	$ 0
D1208	Topical Application of Flouride	$ 0

Other Preventive Services

(Sealants are limited to once per lifetime for permanent molars of eligible dependent children under the age of 19 years)

D1330	Oral Hygiene Instruction	$ 0
D1351	Sealant — Per Tooth	$ 0

Space Maintenance *(Passive Appliances*)

D1510	Space Maintainer — Fixed — Unilateral	$ 0
D1515	Space Maintainer — Fixed — Bilateral	$ 0
D1520	Space Maintainer — Removable — Unilateral	$ 0
D1525	Space Maintainer — Removable — Bilateral	$ 0
D1550	Recementation of Space Maintainer	$ 0
D1555	Removal of Fixed Space Retainer	$ 0

D2000-D2999 III. RESTORATIVE

(The replacement of a crown is covered only after a 5 year period measured from the date on which the crown was previously placed)

Amalgam Restorations *(Including Polishing)*

D2140	Amalgam — One Surface — Primary or Permanent	$ 0
D2150	Amalgam — Two Surfaces — Primary or Permanent	$ 0
D2160	Amalgam — Three Surfaces — Primary or Permanent	$ 0
D2161	Amalgam — Four or More Surfaces — Primary or Permanent	$ 0

Resin Restorations

D2330	Resin-Based Composite — One Surface — Anterior	$ 0
D2331	Resin-Based Composite — Two Surfaces — Anterior	$ 0
D2332	Resin-Based Composite — Three Surfaces — Anterior	$ 0
D2335	Resin-Based Composite — Four or More Surfaces or Involving Incisal Angle — Anterior	$ 0
D2390	Resin-Based Composite Crown — Anterior	$ 35
D2391	Resin-Based Composite — One Surface — Posterior	$ 15
D2392	Resin-Based Composite — Two Surfaces — Posterior	$ 25
D2393	Resin-Based Composite — Three Surfaces — Posterior	$ 35
D2394	Resin-Based Composite — Four or More Surfaces — Posterior	$ 45

Inlay/Onlay Restorations

D2510	Inlay — Metallic — One Surface	$ 100
D2520	Inlay — Metallic — Two Surfaces	$ 100
D2530	Inlay — Metallic — Three or More Surfaces	$ 100
D2542	Onlay — Metallic — Two Surfaces	$ 100
D2543	Onlay — Metallic — Three Surfaces	$ 100
D2544	Onlay — Metallic — Four or More Surfaces	$ 100
D2610	Inlay — Porcelain/Ceramic — One Surface	$ 115
D2620	Inlay — Porcelain/Ceramic — Two Surfaces	$ 115
D2630	Inlay — Porcelain/Ceramic — Three or More Surfaces	$ 115
D2642	Onlay — Porcelain/Ceramic — Two Surfaces	$ 115
D2643	Onlay — Porcelain/Ceramic — Three Surfaces	$ 115
D2644	Onlay — Porcelain/Ceramic — Four or More Surfaces	$ 115
D2650	Inlay — Resin-Based Composite — One Surface	$ 115
D2651	Inlay — Resin-Based Composite — Two Surfaces	$ 115
D2652	Inlay — Resin-Based Composite — Three or More Surfaces	$ 115
D2662	Onlay — Resin-Based Composite — Two Surfaces	$ 115
D2663	Onlay — Resin-Based Composite — Three Surfaces	$ 115
D2664	Onlay — Resin-Based Composite — Four or More Surfaces	$ 115

Crowns — Single Restorations Only

D2710	Crown — Resin-Based Composite (Indirect) *(See note below)*	$ 115
D2720	Crown — Resin with High Noble Metal	$ 150
D2721	Crown — Resin with Predominantly Base Metal	$ 150
D2722	Crown — Resin with Noble Metal	$ 150
D2740	Crown — Porcelain/Ceramic Substrate	$ 200
D2750	Crown — Porcelain Fused to High Noble Metal	$ 225
D2751	Crown — Porcelain Fused to Predominantly Base Metal	$ 200
D2752	Crown — Porcelain Fused to Noble Metal	$ 200
D2780	Crown — 3/4 Cast High Noble Metal	$ 225
D2781	Crown — 3/4 Cast Predominantly Base Metal	$ 200
D2790	Crown — Full Cast High Noble Metal	$ 225
D2791	Crown — Full Cast Predominantly Base Metal	$ 200
D2792	Crown — Full Cast Noble Metal	$ 200
D2794	Crown — Titanium	$ 225

Note: *There is no copayment for procedure D2710 when performed in conjunction with a permanent crown on the same tooth.*

Other Restorative Services

D2910	Recement Inlay, Onlay, or Partial Coverage Restoration	$ 0
D2915	Recement Cast or Prefabricated Post and Core	$ 0
D2920	Recement Crown	$ 0
D2929	Prefabricated Porcelain/Ceramic Crown — Primary Tooth	$ 49
D2930	Prefabricated Stainless Steel Crown — Primary Tooth	$ 35
D2931	Prefabricated Stainless Steel Crown — Permanent Tooth	$ 35
D2932	Prefabricated Resin Crown	$ 35
D2933	Prefabricated Stainless Steel Crown with Resin Window	$ 35
D2934	Prefabricated Esthetic Coated Stainless Steel Crown — Primary Tooth	$ 35
D2940	Protective Restoration	$ 0
D2950	Core Buildup, Including any Pins	$ 0
D2951	Pin Retention — Per Tooth in Addition to Restoration	$ 0
D2952	Cast Post and Core in Addition to Crown	$ 40
D2954	Prefabricated Post and Core in Addition to Crown	$ 40
D2955	Post Removal	$ 0
D2971	Additional Procedures to Construct New Crown Under Existing Partial Denture Framework	$ 0
D2980	Crown Repair Necessitated by Restorative Material Failure	$ 0
D2981	Inlay Repair Necessitated by Restorative Material Failure	$ 0
D2982	Onlay Repair Necessitated by Restorative Material Failure	$ 0
D2983	Veneer Repair Necessitated by Restorative Material Failure	$ 0
D2990	Resin Infiltration of Incipient Smooth Surface Lesions	$ 0

D3000-D3999 IV. ENDODONTICS

Pulp Capping

D3110	Pulp Capping — Direct — Excluding Final Restoration	$ 0
D3120	Pulp Capping — Indirect — Excluding Final Restoration	$ 0

Pulpotomy

D3220	Therapeutic Pulpotomy — Excluding Final Restoration	$ 25

Endodontic Therapy on Primary Teeth

D3230	Pulpal Therapy (Resorbable Filling) — Anterior-Primary Tooth — Excluding Final Restoration	$ 20
D3240	Pulpal Therapy (Resorbable Filling) — Posterior-Primary Tooth — Excluding Final Restoration	$ 20

Endodontic Therapy

D3310	Anterior (Excluding Final Restoration)	$ 100
D3320	Bicuspid (Excluding Final Restoration)	$ 125
D3322	Partial Pulpotomy for Apexogenesis	$ 25
D3330	Molar (Excluding Final Restoration)	$ 150

Endodontic Retreatment

D3346	Retreatment of Previous Root Canal Therapy — Anterior	$ 125
D3347	Retreatment of Previous Root Canal Therapy — Bicuspid	$ 150
D3348	Retreatment of Previous Root Canal Therapy — Molar	$ 175

Apexification/Recalcification Procedures

D3351	Apexification/Recalcification — Initial Visit	$ 35
D3352	Apexification/Recalcification — Interim Medication Replacement	$ 35
D3353	Apexification/Recalcification — Final Visit	$ 35

Apicoectomy/Periapical Services

D3410	Apicoectomy/Periradicular Surgical — Anterior	$ 90
D3421	Apicoectomy/Periradicular Surgical — Bicuspid First Root	$ 90
D3425	Apicoectomy/Periradicular Surgical — Molar First Root	$ 90
D3426	Apicoectomy/Periradicular Surgical — Each Additional Root	$ 40
D3430	Retrograde Filling — Per Root	$ 20
D3450	Root Amputation — Per Root	$ 40

Other Endodontic Procedures

D3910	Surgical Procedure for Isolation of Tooth with Rubber Dam	$ 0
D3920	Hemisection (Including any Root Removal) — Not Including Root Canal Therapy	$ 60

D4000-D4999 V. PERIODONTICS

(Coverage for surgical periodontal procedures, excluding scaling and root planing, is limited to one surgical periodontal treatment per quadrant every 36 months; coverage for scaling and root planing is limited to one nonsurgical periodontal treatment per quadrant every 12 months)

Surgical Services

D4210	Gingivectomy or Gingivoplasty — Four or More Contiguous Teeth or Tooth Bounded Spaces per Quadrant	$ 85
D4211	Gingivectomy or Gingivoplasty — One to Three Contiguous Teeth or Tooth Bounded Spaces per Quadrant	$ 30
D4212	Gingivectomy or Gingivoplasty to Allow Access for Restorative Procedure — Per Tooth	$ 12
D4240	Gingival Flap Procedure Including Root Planing — Four or More Contiguous Teeth or Tooth Bounded Spaces per Quadrant	$ 90
D4241	Gingival Flap Procedure Including Root Planing — One to Three Contiguous Teeth or Tooth Bounded Spaces per Quadrant	$ 60
D4245	Apically Positioned Flap	$ 90
D4249	Clinical Crown Lengthening — Hard Tissue	$ 90
D4260	Osseous Surgery (Including Flap Entry and Closure) — Four or More Contiguous Teeth or Tooth Bounded Spaces per Quadrant	$ 175
D4261	Osseous Surgery (Including Flap Entry and Closure) — One to Three Contiguous Teeth or Tooth Bounded Spaces per Quadrant	$ 100

D4263	Bone Replacement Graft — First Site in Quadrant	$ 100
D4264	Bone Replacement Graft — Each Addition Site in Quadrant	$ 50
D4266	Guided Tissue Regeneration — Resorbable Barrier per Site	$ 90
D4267	Guided Tissue Regeneration — Non-resorbable Barrier per Site (Includes Membrane Removal)	$ 90
D4270	Pedicle Soft Tissue Graft Procedure	$ 175
D4271	Free Soft Tissue Graft Procedure (Including Donor Site Surgery)	$ 175
D4273	Subepithelial Connective Tissue Graft Procedure — per Tooth	$ 175
D4274	Distal or Proximal Wedge Procedure (When Not Performed in Conjunction with Surgical Procedures in theSame Anatomical Area)	$ 40
D4275	Soft Tissue Allograft	$ 175
D4276	Combined Connective Tissue and Double Pedicle Graft — Per Tooth	$ 175
D4277	Free Soft Tissue Graft Procedure (Including Donor Site Surgery) — First Tooth or Edentulous Tooth Position in a Graft	$ 70
D4278	Free Soft Tissue Graft Procedure (Including Donor Site Surgery) — Each Additional Contiguous Tooth or Edentulous Tooth Position in a Graft	$ 35

Non-Surgical Periodontal Services

D4320	Provisional Splinting — Intracoronal	$ 0
D4321	Provisional Splinting — Extracoronal	$ 0
D4341	Periodontal Scaling and Root Planing — Four or More Teeth per Quadrant	$ 55
D4342	Periodontal Scaling or Root Planing — One to Three Teeth per Quadrant	$ 40
D4355	Full Mouth Debridement to Enable Comprehensive Periodontal Evaluation and Diagnosis	$ 55

Other Periodontal Services

D4910	Periodontal Maintenance	$ 30
D4920	Unscheduled Dressing Change (By Someone Other than Treating Dentist)	$ 0

D5000-D5999 VI. PROSTHODONTICS (REMOVABLE)

(The replacement of an existing removable prosthetic appliance is covered only after a 5 year period measured from the date on which the appliance was previously placed)

Complete Dentures *(Including Routine Post Delivery Care)*

D5110	Complete Denture — Maxillary	$ 250
D5120	Complete Denture — Mandibular	$ 250
D5130	Immediate Denture — Maxillary	$ 275
D5140	Immediate Denture — Mandibular	$ 275

Partial Dentures *(Including Routine Post Delivery Care)*

D5211	Maxillary Partial Denture — Resin Base (Including any Conventional Clasps, Rests, and Teeth)	$ 250
D5212	Mandibular Partial Denture — Resin Base (Including any Conventional Clasps, Rests, and Teeth)	$ 250
D5213	Maxillary Partial Denture — Cast Metal Framework w/Resin Denture Bases (Including any Conventional Clasps, Rests, and Teeth)	$ 275
D5214	Mandibular Partial Denture — Cast Metal Framework w/Resin Denture Bases (Including any Conventional Clasps, Rests, and Teeth)	$ 275
D5225	Maxillary Partial Denture — Flexible Base (Including any Clasps, Rests, and Teeth)	$ 300
D5226	Mandibular Partial Denture — Flexible Base (Including any Clasps, Rests, and Teeth)	$ 300
D5281	Removable Unilateral Partial Denture — One Piece Cast Metal (Including Clasps and Teeth)	$ 125

Adjustments to Removable Prostheses

D5410	Adjust Complete Denture — Maxillary	$ 0
D5411	Adjust Complete Denture — Mandibular	$ 0
D5421	Adjust Partial Denture — Maxillary	$ 0
D5422	Adjust Partial Denture — Mandibular	$ 0

Repairs to Complete Dentures

D5510	Repair Broken Complete Denture Base	$ 35
D5520	Replace Missing or Broken Teeth — Complete Denture — Each Tooth	$ 35

Repairs to Partial Dentures

D5610	Repair Resin Denture Base	$ 35
D5620	Repair Cast Framework	$ 35
D5630	Repair or Replace Broken Clasp	$ 35
D5640	Replace Broken Teeth — Per Tooth	$ 35
D5650	Add Tooth to Existing Partial Denture	$ 35
D5660	Add Clasp to Existing Partial Denture	$ 35

Denture Rebase Procedures

D5710	Rebase Complete Maxilary Denture	$ 85
D5711	Rebase Complete Mandibular Denture	$ 85
D5720	Rebase Maxillary Partial Denture	$ 85
D5721	Rebase Mandibular Partial Denture	$ 85

Denture Reline Procedures

D5730	Reline Complete Maxillary Denture — Chairside	$ 40
D5731	Reline Complete Mandibular Denture — Chairside	$ 40
D5740	Reline Maxillary Partial Denture — Chairside	$ 40

D5741	Reline Mandibular Partial Denture — Chairside	$ 40
D5750	Reline Complete Maxillary Denture — (Lab Process)	$ 40
D5751	Reline Complete Mandibular Denture — (Lab Process)	$ 40
D5760	Reline Maxillary Partial Denture — (Lab Process)	$ 40
D5761	Reline Mandibular Partial Denture — (Lab Process)	$ 40

Other Removable Prosthetic Services

D5810	Interim Complete Denture (Maxillary)	$ 40
D5811	Interim Complete Denture (Mandibular)	$ 40
D5820	Interim Partial Denture (Maxillary)	$ 40
D5821	Interim Partial Denture (Mandibular)	$ 40
D5850	Tissue Conditioning (Maxillary)	$ 40
D5851	Tissue Conditioning (Mandibular)	$ 40

D6200-D6999 IX. PROSTHODONTICS, FIXED

Fixed Partial Denture Pontics

D6210	Pontic — Cast High Noble Metal	$ 225
D6211	Pontic — Cast Predominantly Base Metal	$ 200
D6212	Pontic — Cast Noble Metal	$ 200
D6214	Pontic — Titanium	$ 225
D6240	Pontic — Porcelain Fused to High Noble Metal	$ 225
D6241	Pontic — Porcelain Fused to Predominantly Base Metal	$ 200
D6242	Pontic — Porcelain Fused to Noble Metal	$ 200
D6245	Pontic — Porcelain/Ceramic	$ 200
D6250	Pontic — Resin with High Noble Metal	$ 150
D6251	Pontic — Resin with Predominantly Base Metal	$ 150
D6252	Pontic — Resin with Noble Metal	$ 150

Fixed Partial Denture Retainers — Inlays/Onlays

D6545	Retainer — Cast Metal for Resin Bonded Fixed Prosthesis	$ 100
D6602	Inlay — Cast High Noble Metal — Two Surfaces	$ 175
D6603	Inlay — Cast High Noble Metal — Three or More Surfaces	$ 175
D6604	Inlay — Cast Predominantly Base Metal — Two Surfaces	$ 100
D6605	Inlay — Cast Predominantly Base Metal — Three or More Surfaces	$ 100
D6606	Inlay — Cast Noble Metal — Two Surfaces	$ 155
D6607	Inlay — Cast Noble Metal — Three or More Surfaces	$ 155
D6610	Onlay — Cast High Noble Metal — Two Surfaces	$ 185
D6611	Onlay — Cast High Noble Metal — Three or More Surfaces	$ 185
D6612	Onlay — Cast Predominantly Base Metal — Two Surfaces	$ 100
D6613	Onlay — Cast Predominantly Base Metal — Three or More Surfaces	$ 100
D6614	Onlay — Cast Noble Metal — Two Surfaces	$ 175
D6615	Onlay — Cast Noble Metal — Three or More Surfaces	$ 175
D6624	Inlay — Titanium	$ 175
D6634	Onlay — Titanium	$ 185

Fixed Partial Denture Retainers — Crown

D6720	Crown — Resin with High Noble Metal	$ 150
D6721	Crown — Resin with Predominantly Base Metal	$ 150
D6722	Crown — Resin with Noble Metal	$ 150
D6740	Crown — Porcelain/Ceramic	$ 200
D6750	Crown — Porcelain Fused to High Noble Metal	$ 225
D6751	Crown — Porcelain Fused to Predominantly Base Metal	$ 200
D6752	Crown — Porcelain Fused to Noble Metal	$ 200
D6780	Crown — 3/4 Cast High Noble Metal	$ 225
D6781	Crown — 3/4 Cast Predominantly Base Metal	$ 200
D6782	Crown — 3/4 Cast Noble Metal	$ 200
D6783	Crown — 3/4 Porcelain/Ceramic	$ 200
D6790	Crown — Full Cast High Noble Metal	$ 225
D6791	Crown — Full Cast Predominantly Base Metal	$ 200
D6792	Crown — Full Cast Noble Metal	$ 200
D6794	Crown — Titanium	$ 225

Other Fixed Partial Denture Services

D6930	Recement Fixed Partial Denture	$ 15
D6970	Cast Post and Core in Addition to Bridge Retainer	$ 40
D6972	Prefabricated Post and Core in Addition to Bridge Retainer	$ 40
D6973	Core Buildup for Retainer Including Pins	$ 0
D6980	Fixed Partial Denture Repair Necessitated by Restorative Material Failure	$ 25

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

Extractions

(Includes local anesthesia, suturing, if needed, and routine post-operative care)

D7111	Extraction — Coronal Remnants — Deciduous Tooth	$ 10
D7140	Extraction — Erupted Tooth or Exposed Root (Elevation and/or Forceps Removal)	$ 20

Surgical Extractions

(Includes local anesthesia, suturing, if needed, and routine post-operative care)

D7210	Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth	$ 30
D7220	Removal of Impacted Tooth — Soft Tissue	$ 55
D7230	Removal of Impacted Tooth — Partially Bony	$ 55
D7240	Removal of Impacted Tooth — Completely Bony	$ 65
D7241	Removal of Impacted Tooth — Completely Bony with Complications	$ 65
D7250	Surgical Removal of Residual Tooth Roots — Cutting Procedure	$ 30

Other Surgical Procedures

D7260	Oroantral Fistula Closure	$ 100
D7270	Tooth Reimplantation/Stabilization	$ 60
D7280	Surgical Access of an Unerupted Tooth	$ 60
D7282	Mobilization of Erupted or Malpositioned Tooth to Aid Eruption	$ 60
D7283	Placement of Device to Facilitate Eruption of Impacted Tooth	$ 0
D7285	Biopsy of Oral Tissue — Hard (Bone, Tooth)	$ 60
D7286	Biopsy of Oral Tissue — Soft	$ 25
D7291	Transseptal Fiberotomy Supra Crestal Fiberotomy — By Report	$ 20

Alveoloplasty-Surgical Preparation of the Ridge for Dentures

D7310	Alveoloplasty in Conjunction with Extraction — Per Quadrant	$ 30
D7311	Alveoloplasty in Conjunction with Extractions — One to Three Teeth or Tooth Spaces per Quadrant	$ 15
D7320	Alveoloplasty Not in Conjunction with Extractions — Per Quadrant	$ 35
D7321	Alveoloplasty Not in Conjunction with Extractions — One to Three Teeth or Tooth Spaces per Quadrant	$ 20

Removal of Cysts, Tumors, and Neoplasms

D7450	Removal of Benign Odontogenic Cyst or Tumor — Lesion Up to 1.25 cm Diameter	$ 60
D7451	Removal of Benign Odontogenic Cyst or Tumor — Lesion Greater than 1.25 cm Diameter	$ 60
D7460	Removal of Benign Non-Odontogenic Cyst or Tumor — Leision Up to 1.25 cm Diameter	$ 60
D7461	Removal of Benign Non-Odontogenic Cyst or Tumor — Leision Greater than 1.25 cm Diameter	$ 60

Excision of Bone Tissue

D7471	Removal of Lateral Exostosis — Maxilla or Mandible	$ 90
D7472	Removal Torus Palatinus	$ 90
D7473	Removal Torus Mandibularis	$ 90
D7485	Surgical Reduction of Osseous Tuberosity	$ 90

Surgical Incision

D7510	Incision and Drainage of Abscess — Intraoral — Soft Tissue	$ 25
D7511	Incision and Drainage of Abscess — Intraoral — Soft Tissue — Complicated (Includes Drainage of Multiple Facial Spaces)	$ 30
D7520	Incision and Drainage of Abscess — Extraoral — Soft Tissue	$ 35
D7521	Incision and Drainage of Abscess — Extraoral — Soft Tissue — Complicated (Includes Drainage of Multiple Facial Spaces)	$ 40

Other Repair Procedures

D7953	Bone Replacement Graft for Ridge Preservation — Per Site	$ 75
D7960	Frenulectomy — Separate Procedure	$ 60

D7963	Frenuloplasty	$ 65
D7970	Excision of Hyperplastic Tissue — Per Arch	$ 60
D7971	Excision of Pericoronal Gingiva	$ 30
D7972	Surgical Reduction of Fibrous Tuberosity	$ 60

Miscellaneous Services

D9110	Palliative (Emergency) Treatment of Dental Pain — Minor Procedure	$ 0
D9211	Regional Block Anesthesia	$ 0
D9212	Trigeminal Division Block Anesthesia	$ 0
D9215	Local Anesthesia	$ 0
D9220	Deep Sedation/General Anesthesia — First 30 Minutes	$ 40
D9221	Deep Sedation/General Anesthesia — Each Additional 15 Minutes	$ 20
D9230	Analgesia, Anxiolysis, Inhalation of Nitrous Oxide	$ 0
D9241	Intravenous Conscious Sedation/Analgesia — First 30 Minutes	$ 40
D9242	Intravenous Conscious Sedation/Analgesia — Each Additional 15 Minutes	$ 20
D9310	Consultation *(Diagnostic Service Provided by a Dentist or Physician other than Practitioner Providing Treatment)*	$ 0
D9430	Office Visit Observation	$ 0
D9440	Office Visit After Hours	$ 0
D9610	Therapeutic Drug Injection — By Report	$ 0
D9630	Other Drugs and/or Medications — By Report	$ 0
D9910	Application of Desensitizing Medication	$ 0
D9930	Treat Complications — By Report	$ 0
D9940	Occlusal Guard — By Report	$ 40
D9942	Repair and/or Reline of Occlusal Guard	$ 20
D9951	Occlusal Adjustment — Limited	$ 0
D9952	Occlusal Adjustment — Complete	$ 60

Orthodontics

Treatment plan maximum of 24 months.

1. Patient under 18 years of age at the start of treatment — Class I, II, and III malocclusion (copayment required of $1,000 or 50 percent of reasonable and customary charges, whichever is less).
2. Patient 18 years of age or over at the start of treatment — Class I, II, and III malocclusion (copayment required of $1,750 or 50 percent of reasonable and customary charges, whichever is less). Includes Invisalign as an optional treatment procedure — this procedure may fall under the "More Expensive Services" option and as such, the member choosing this option would be responsible for the difference between Invisalign charges and the standard adult orthodontic charge.

More Expensive Services

A covered individual may elect a more expensive procedure than an appropriate procedure recommended by the dentist. The covered individual shall pay any copayment required for the less expensive procedure plus the difference in cost between the two procedures on the basis of the reasonable and customary dental charges for the procedures.

Emergency Services — Out-of-Area

Emergency Treatment is defined as, "when a covered SHBP (or SEHBP) member or dependent is at least 50 miles from home, any necessary service or procedure which is rendered as the direct result of an 'unforeseen' occurrence and requires immediate, urgent action or remedy". Examples are, acute pain, bleeding, fractured tooth, broken filling, broken front tooth, broken denture, and lost or loose crown. The reimbursement shall be at the full amount of the charge up to a maximum of $100 per episode.

SERVICES THAT ARE NOT COVERED BY THE DPO

- A service started before the person became a covered individual under the plan.
- Replacement of lost, stolen, or damaged prosthodontic devices within two years of the date of initial installation.
- A service not reasonably necessary for the dental care of a covered individual or provided solely for cosmetic purposes.
- Providing supplies of a type normally intended for home use, such as toothpaste, toothbrushes, waterpicks, and mouthwash.
- A service required because of war or an act of war.
- A service made available to a covered individual or financed by the federal, state, or local government. This includes the federal Medicare program and any similar federal program, any Workers' Compensation law or similar law, any automobile no-fault law, or any other program or law under which the covered individual is, or could be, covered. The exclusion is applicable whether or not the covered individual receives the service, makes a claim or receives compensation for the service, or receives a recovery from a third party for damages.
- A service not furnished by a dentist or physician licensed to provide the dental service, except for a service performed by a licensed dental hygienist under the direction of a dentist.
- General anesthesia, except when medically necessary in connection with covered oral and periodontal surgery procedures.
- Hospitalization.
- Any dental implant including any crowns, prostheses, devices, or appliances attached to implants.
- Experimental procedures.
- Appliances, restorations, and procedures to alter vertical dimension and/or restore occlusion, including temporomandibular joint dysfunction, except oral splints.
- Procedures that are not listed.
- A service covered under any medical, surgical, or major medical plan (including a Health Maintenance Organization — HMO) provided by the employer.

SECTION FOUR

THE DENTAL EXPENSE PLAN

The Dental Expense Plan is an indemnity plan that reimburses for a portion of the expenses incurred for dental care provided by dentists or physicians licensed to perform dental services in the state in which they are practicing. Not all dental services are eligible for reimbursement, and some services are eligible only up to a limited amount. (For example, orthodontic services are reimbursed differently than other services.)

Diagnostic/preventive and orthodontic services, are not subject to an annual deductible. For all other services, an annual deductible amount must be met before benefits are payable. You are responsible for making the full payment of all charges to your dentist.

Effective January 1, 2012, the Employee Dental Expense Plan changed from a passive Preferred Provider Prganization (PPO) benefit design in which employees have the same coinsurance for both in-network and out-of-network providers to a true PPO. The change to a true PPO plan for active employees increased the member's share of the coinsurance when using out-of-network providers. If your current dentist is an in-network provider, you will not see any change to your dental benefits. The plan change to a true PPO does not change the $50 in-network deductible or $3,000 benefit maximum.

The Dental Expense Plan has been established by the State as a self-funded plan. The State currently contracts with Aetna Dental to act as the administrative agent for the Dental Expense Plan.

As a Dental Expense Plan member, you may be able to take advantage of a special Aetna network of participating dental providers. In this network, participating dental providers contract with Aetna for a discounted fee schedule. When using a participating dental provider, you only pay the provider any applicable deductible and the appropriate coinsurance based on the discounted fee, thereby reducing your out-of-pocket cost. In many cases the participating dental provider will submit the claims directly to Aetna, eliminating the necessity of filing claim forms.

To find out if your provider participates in the discounted network, call Aetna at 1-877-238-6200 or log onto Aetna's online provider directory, DocFind, at: *www.aetna.com*

Annual Deductible

Diagnostic/Preventive and **Orthodontic** services are not subject to a deductible amount..

For other services, the first $50 of covered expenses that you or your dependent(s) incur in a calendar year is not eligible for reimbursement. However, if there are four or more members of your family in the Dental Expense Plan, no additional deductibles are charged after any three members have each met their $50 deductible.

Reasonable and Customary Charges

The Dental Expense Plan covers only that part of a provider's charge for a service or supply that is reasonable and customary. Generally speaking, a charge by your dentist, or by any other provider of services or supplies, is considered reasonable and customary if it doesn't exceed the

prevailing charge for the same service or supply made by similar providers in the same geographic area. It may differ from the actual amount that your dentist charges. You are responsible for the amount the dentist charges above the reasonable and customary allowances.

DENTAL EXPENSE PLAN BENEFITS

	In-Network	Out-of-Network
Deductible / Calendar Year	$50 / Individual $100 / Family Wavied for Preventive Care	$75 / Individual $150 / Family Waived for Preventive Care
Coinsurance (as percentage of R&C)	100% Preventive 80% Basic Restorative 65% Major Restorative 50% Periodontics & Prosthodontics	90% Preventive 70% Basic Restorative 55% Major Restorative 40% Periodontics & Prosthodontics
Maximum Annual Benefit / Individual	$3,000	$2,000 (maximum of $3,000 combined in and out-of-network)
Orthodontia Under Age 19	50% to 1,000 lifetime maximum (not subject to deductible) (maximum not combined with Annual Maximum)	40% to $750 lifetime (maximum of $1,000 combinded in and out-of-network) (not subject to deductible) (maximum not combined with Annual Maximum)

COVERED SERVICES

A general description of each category of service is provided below. Refer to "Services that are Eligible for Reimbursement" on page 29 for any limitations that may apply to these services.

Diagnostic and Preventive Services are precautionary services and are intended to maintain oral health and reduce the effects of tooth decay or gum disease which could lead to an increased need for more costly restorative services. They include the following:

- Oral Evaluations (includes comprehensive, periodic, limited, and specialist oral evaluations)
- Prophylaxis (cleaning of the teeth, including scaling and polishing procedures)
- Fluoride Treatments (topical application of fluoride for children under age 19)
- X-rays (limitations may apply)
- Laboratory and other Diagnostic Tests

Basic Services include:

- Emergency Treatment (Palliative only)
- Space Maintainers (i.e., passive appliances — can be fixed or removable)
- Simple Extractions

- Surgical Extractions
- Oral Surgery
- Anesthesia Services
- Basic Restorations (i.e., amalgam restorations and resin restorations)
- Endodontics (i.e., treatment of diseases of the dental pulp, including root canal and associated therapy)
- Repairs to removable dentures

Major Restorative Services include those services that restore existing teeth. These services are utilized only if a tooth cannot be restored with an amalgam, acrylic, synthetic porcelain, or composite filling restoration. Inlays, onlays, and crowns are typical examples of major restorative services.

Periodontal Services include those services involving the maintenance, reconstruction, regeneration, and treatment of the supporting structures surrounding teeth, including bone, gum tissue, and root surfaces.

Prosthodontic Services include both removable and fixed dentures (bridges) replacing missing teeth.

Orthodontic Services include services to correct abnormalities in tooth position (malposition) or abnormal bite (malocclusion), using appliances such as retainers or braces (see page 30).

Annual and Lifetime Benefit Maximums

The most the Dental Expense Plan will pay for any one person in any one calendar year is $3,000 — combined in-network and out-of-network. This maximum applies to all eligible services except orthodontic, which has a separate $1,000 lifetime benefit maximum.

In-Network and Out-of-Network Integration

The in-network maximum is $3,000 and the out-of-network maximum is $2,000. Furthermore, they are integrated. This means that, if you receive services out-of-network and reach the out-of-pocket maximum of $2,000, the $2,000 carries forward towards the $3,000 in-network maximum leaving only $1,000 remaining for in-network services. Examples of how in-network and out-of-network claims are paid are shown in the following charts.

IN-NETWORK CLAIMS

Procedure	DDS Charge	PPO Allowance	Deductible	Coinsurance	Plan Pays	Member Responsibility
Abutment	$1,250.00	$785.00	$50.00	50%	$367.50	$417.50
Pontic	$1,250.00	$785.00	$0.00	50%	$392.50	$392.50
Abutment	$1,250.00	$726.00	$0.00	50%	$363.00	$363.00
Totals	$3,750.00	$2,296.00	$50.00	—	$1,123.00	$1,173.00

OUT-OF-NETWORK CLAIMS

Procedure	DDS Charge	PPO Allowance	Deductible	Coinsurance	Plan Pays	Member Responsibility
Abutment	$1,250.00	$1,150.00	$75.00	40%	$430.00	$820.00
Pontic	$1,250.00	$1,150.00	$0.00	40%	$500.00	$750.00
Abutment	$1,250.00	$1,150.00	$0.00	40%	$500.00	$750.00
Totals	$3,750.00	$3,450.00	$75.00	—	$1,430.00	$2,320.00

ADDITIONAL PROVISIONS OF THE DENTAL EXPENSE PLAN

How Payments are Made

Normally, reimbursements will be made to the Dental Expense Plan subscriber. The Dental Expense Plan subscriber may, however, authorize Aetna to send the reimbursement directly to the dental provider by completing the appropriate part of the claim form.

Additionally, whenever a law or court order requires the payment of dental expense benefits under the Dental Expense Plan to be made to a person or facility other than the Dental Expense Plan subscriber, the payment will be made to that person or facility upon proper notification (letter and a copy of the order/law).

Filing Deadline — Proof of Loss

Aetna must be given written proof that a dental service has been performed for which a claim is made under the coverage. This proof must cover the occurrence, character, and extent of the service. It must be furnished within 27 months of the date of service. For example, if a service were incurred in February 1, 2012, you would have until April 30, 2015 to file the claim.

A claim will not be considered valid unless proof of the service is furnished within the time limit indicated above. If it is not possible for you to provide proof within the time limit, the claim may be considered valid upon appeal if the reason the proof was not provided in a timely basis was reasonable.

Itemized Bills are Necessary

You must obtain itemized bills from the providers of services for all dental expenses. The itemized bills must include the following:

- Name and address of provider
- Provider's tax identification number
- Name of patient
- Subscriber’s identification number
- Date of service

- Type of service
- Procedure code (CDT-2013 Code)
- Charge for each service

Predetermination of Benefits

Predetermination is voluntary and allows you to know what services are covered and what payments will be made for treatment before the work is done. If you or one of your dependents are likely to incur dental expenses over $300, it is strongly recommended that you ask your dentist to file for predetermination of benefits.

This feature of the Dental Expense Plan ensures that both you and the dentist will know in advance what part of the dentist's charges the Dental Expense Plan will pay. If possible, treatment should be completed within 90 days of receiving the approved predetermination.

The predetermination of benefits provision of the Dental Expense Plan is important, because under the alternative procedures provision (see "Alternative Procedures" below), Aetna has the right to pay the reasonable and customary allowance for the method of treatment that is proper and is economically sound.

How Predetermination of Benefits Works — Your dentist submits a treatment plan and Aetna determines the amount the Dental Expense Plan will pay and informs you and the dentist of its payment decision. You and your dentist should discuss the predetermination before the work is started.

Predetermination of benefits will help you avoid surprises. Most dentists are familiar with predetermination procedures, but if not, they should call Aetna at 1-877-238-6200. If your dentist submits a treatment plan for predetermination of benefits and then alters the course of treatment, Aetna will adjust its payments accordingly. If the dentist makes a major change in the treatment plan, he or she should send in a revised plan.

Alternative Procedures

Usually there are several ways to treat a particular dental problem. Payment will be based on the least costly treatment as determined by Aetna so long as the treatment meets acceptable dental standards. If you and the dentist decide you want a more costly treatment method, you are responsible for the charges beyond those for the less costly, appropriate treatment.

SERVICES THAT ARE ELIGIBLE FOR REIMBURSEMENT

Even though a service or supply may not be described or listed in this handbook, that does not make the service or supply eligible for a benefit under this plan.

- Oral evaluations (limited to twice in a Calendar year). Emergency or limited oral evaluations are limited to once in a Calendar year, per patient — covered at 100 percent of the reasonable and customary charges (see page 24).
- X-rays (horizontal bitewing X-rays limited to two series of up to 4 films in a Calendar year; vertical bitewing X-rays limited to two series of up to 8 films per Calendar year; set of full mouth or panoramic X-rays limited to once per 36-month interval; no more than 18 films per set of full mouth periapical X-rays).
- Oral prophylaxis, including scaling (not including scaling performed by a periodontist) and polishing (limited to twice in a Calendar year).
- Topical application of fluoride for children under age 19 limited to twice in a Calendar year.
- Sealants (limited to once per lifetime for permanent molars of eligible dependent children under the age of 19 years).
- Prosthodontic procedures (the replacement of an existing fixed or removable prosthetic appliance is covered only after a 5-year period measured from the date on which the appliance was previously placed).
- Periodontic procedures (reimbursement for periodontal surgical procedures and follow-up maintenance, usually provided for a specific quadrant, is limited to one surgical-type procedure every 36 months). Reimbursement for periodontal scaling and root planing procedures per specific quadrant is limited to one procedure per 12-month interval.
- Restorative procedures, including fillings, inlays, onlays, and crowns (the replacement of a crown is covered only after a 5-year period measured from the date on which the crown was previously placed).
- Emergency palliative treatment.
- Extractions of teeth.
- Endodontic services, such as pulpotomy and root canal therapy.
- Space maintainers.
- Oral surgery for surgical extractions, treatment of fractures, removal of lesions of the mouth, alveolectomy, and biopsy of hard and soft tissue.
- Apicoectomy.
- General anesthesia (including conscious sedation coverage) when medically necessary and in connection with covered oral and periodontal surgical procedures.

ORTHODONTIC SERVICES THAT ARE ELIGIBLE FOR REIMBURSEMENT

Certain charges for orthodontic procedures are eligible if:

- You have been a full-time employee for at least 10 months.
- The orthodontic treatment is for a child covered under the Dental Expense Plan who is less than 19 years old.
- The procedure involves the use of active appliances to move teeth in order to correct the faulty position of teeth (malposition) or abnormal bite (malocclusion).
- The service or supply is part of a treatment plan submitted by the dentist and approved by Aetna with an estimate of the benefits that are payable.
- The service or supply is furnished before the end of the estimated duration of the treatment as recorded in the treatment plan.
- An active appliance for the procedure is inserted while the person is eligible for benefits in this program.

Orthodontic Benefits

In-Network Eligible orthodontic services will be covered at 50 percent, up to a lifetime benefit maximum of $1,000.

Out-of-Network orthodontic services will be covered at 40 percent, up to a lifetime benefit maximum of $750 (maximum of $1,000 combined in and out-of-network).

There is no deductible for orthodontic services.

Note: See page 32 for “Orthodontic Charges that are Not Eligible Under the Dental Expense Plan”.

SERVICES THAT ARE NOT ELIGIBLE FOR REIMBURSEMENT

- Any orthodontic service prior to the employee attaining 10 months of employment or for any member over 19 years of age. (See the separate section for special coverage for orthodontic services on page 30.)
- Gold restorations other than crowns, inlays, and onlays.
- Any service or item not reasonably necessary for the dental care of the patient.
- Endosteal, subperiosteal, and transosteal tooth implants.
- Protective devices such as athletic mouth guards, plaque control, or myofunctional therapy.
- Services and/or appliances that are for the primary purpose of altering vertical dimension (change the way natural teeth meet), including full mouth rehabilitation (crowning all or most of the teeth), splinting teeth with crowns, fillings, appliances, or any method or service that restores occlusion or incisal tooth structure lost from attrition, erosion, abrasion, or any other cause.
- Crowns, inlays, and onlays if used in splinting procedures during periodontal treatment.
- A service for cosmetic purposes.
- Any charge for a supply that is normally for home use such as toothpaste, toothbrushes, water-pick, or mouthwash.
- A dental examination when required as a condition of employment by an employer, a government agency, or the terms of a labor agreement.
- Charges for services that are not reasonably necessary made to produce a professionally acceptable result.
- A service or supply due to a war or any act of war.
- A service not furnished by a dentist or physician licensed to provide the dental service, except for a service performed by a licensed dental hygienist under the direction of a dentist.
- A service rendered by a provider that is beyond the scope of the provider's license.
- A charge made by a dentist for a failure of the patient to keep an appointment.
- A charge for the completion of any claim forms.
- A charge in connection with any procedure started before the patient was eligible for reimbursement in this program; except that a procedure will not have been considered to have started with an oral prophylaxis or a diagnostic procedure.
- Any service or supply other than those specifically covered under this program.
- Hospitalization.
- Experimental procedures.

- A service covered under any medical, surgical, or major medical plan (including a Health Maintenance Organization — HMO) provided by the employer.
- A service made available to a covered individual or financed by the federal, state, or local government. This includes the federal Medicare program and any similar federal program, any Workers' Compensation law or similar law, any automobile no-fault law, or any other program or law under which the covered individual is, or could be, covered. The exclusion is applicable whether or not the covered individual receives the service, makes a claim or receives compensation for the service, or receives a recovery from a third party for damages.
- Any charge incurred after the patient is no longer covered, except in the case of an Extension of Coverage (see page 7).
- Any charge for a service that is more than the reasonable and customary dental charge.
- Any charge for a service rendered by a member of the patient's immediate family (including you, your spouse or eligible same-sex domestic partner, your child, brother, sister, or parent of you or your spouse or eligible same-sex domestic partner).
- Charges for sterilization or asepsis.

Orthodontic Charges that are Not Eligible Under the Dental Expense Plan

- Charges that are eligible for coverage under the regular dental care portion of the program.
- Charges for an orthodontic procedure started prior to the day on which the person became covered under the program or eligible for orthodontic benefits.
- Charges not reasonably necessary for orthodontic care.
- Any charges incurred for orthodontic procedures or treatment begun on or after the date the person attains age 19.

APPENDIX I

CLAIM APPEAL PROCEDURES

You or your authorized representative may appeal and request that your dental plan reconsider any claim or any portion(s) of a claim for which you believe benefits have been erroneously denied based on the plan's limitations and/or exclusions. This appeal may be of an administrative or medical/dental nature. Administrative appeals might question eligibility or plan benefit decisions such as whether a particular service is covered or paid appropriately. Medical appeals refer to the determination of medical/dental need, appropriateness of treatment, or experimental and/or investigational procedures.

The following information must be given at the time of each inquiry.

- Name(s) and address(es) of patient and employee;
- Employee's identification number;
- Date(s) of service(s);
- Provider's name and identification number;
- The specific remedy being sought; and
- The reason you think the claim should be reconsidered.

If you have any additional information or evidence about the claim that was not given when the claim was first submitted, be sure to include it.

Any member of the Dental Expense Plan who disagrees with a final decision of Aetna may request, in writing, that the matter be considered by the State Health Benefits Commission. Requests for consideration must be directed to the *Appeals Coordinator, State Health Benefits Commission, PO Box 299, Trenton, NJ 08625-0299* and must contain the reason for the disagreement and a copy of all relevant correspondence. Appeals are considered at regular monthly meetings of the Commission. It is the responsibility of the member to provide the Commission with any medical or other information that the Commission may require in order to make a decision.

Any member of a Dental Plan Organization (DPO) who disagrees with a determination of the appropriateness of a procedure made by a DPO or any member of a DPO who feels that the DPO has violated the terms and conditions of its contract with the SHBP may request, in writing, that the matter be considered by the State Health Benefits Commission. Such an appeal can only be considered after the member has exhausted the DPO's grievance process.

Upon request, your DPO will supply you with its grievance procedures. Requests for consideration must be directed to the *Appeals Coordinator, State Health Benefits Commission, PO Box 299, Trenton, NJ 08625-0299* and must contain the reason for the disagreement and a copy of all relevant correspondence and supporting documentation. Appeals are considered at regular monthly meetings of the Commission.

Notification of all Commission decisions will be made in writing to the member. If the Commission denies the member's appeal, the member will be informed of further steps (s)he may take in the denial letter from the Commission. Any member who disagrees with the Commission's decision may request within 45 days in writing to the Commission that the case be forwarded to the Office of Administrative Law. The Commission will then determine if a factual hearing is necessary. If so, the case will be forwarded to the Office of Administrative Law. An Administrative Law judge will hear the case and make a recommendation to the Commission, which the Commission may adopt, modify, or reject. If a factual hearing is not necessary, the administrative appeal process involving the Commission is ended. When the administrative process is completed, further appeals may be made to the Superior Court of New Jersey, Appellate Division.

If your case is forwarded to the Office of Administrative Law, you will be responsible for the presentation of your case and for submitting all evidence. You will be responsible for any expenses involved in gathering evidence or material that will support your grounds for appeal. If you take your appeal to Superior Court, you will be responsible for any court filing fees or similar related costs that may be necessary during the appeal's process. If you require an attorney or expert medical testimony, you will be responsible for any fees or costs incurred.

APPENDIX II

GLOSSARY

Alveolectomy — Surgical excision of a portion of the dentoalveolar process, for re-contouring the tooth socket ridge at the time of tooth removal in preparation for a dental prosthesis (denture).

Amalgam — An alloy used in dental restoration.

Apicoectomy — Surgical removal of a dental root apex. Root resection.

Appeal — A request made by a member, doctor, or facility that a carrier review a decision concerning a claim. Administrative appeals question plan benefit decisions such as whether a particular service is covered or paid appropriately. Medical appeals refer to the determination of need or appropriateness of treatment or whether treatment is considered experimental or educational in nature. Appeals to the State Health Benefits Commission may only be filed by a member or the member's legal representative.

Bitewing X-Ray — X-rays taken with the film holder held between the teeth and the film parallel to the teeth.

Calendar Year — A year starting January 1 and ending on December 31.

Civil Union Partner — A person of the same sex with whom you have entered into a civil union. A photocopy of the *New Jersey Civil Union Certificate* or a valid certification from another jurisdiction that recognizes same-sex civil unions and additional supporting documentation are required for enrollment. The cost of civil union partner coverage may be subject to federal tax (see your employer or Fact Sheet #75, *Civil Unions,* for details).

COBRA — Consolidated Omnibus Budget Reconciliation Act of 1985. This federal law requires private employers with more than 20 employees and all public employers to allow covered employees and their dependents to remain on group insurance plans for limited time periods at their own expense under certain conditions.

Coinsurance — The portion of an eligible charge which is the member's financial responsibility.

Coordination of Benefits — The practice of correlating the payments a plan makes with payments provided by other insurance covering the same charges or expenses, so that (1) the plan with primary responsibility pays first, (2) reimbursement by the two plans does not exceed 100 percent of the allowable expense, and (3) the dental plan does not pay more than it would if no other insurance existed.

Copayment — The portion of an eligible charge under a DPO which is the member’s financial responsibility.

Crossbite — An abnormal relation of one or more teeth of one arch to the opposing tooth or teeth of the other arch.

Crown — That part of a tooth that is covered with enamel or an artificial substitute for that part.

Deductible — The first eligible expense, or portion thereof, incurred within each calendar year that the member is required to pay before reimbursement for eligible expenses begins.

Dependent Coverage — Coverage of an eligible family member of an enrolled member.

Domestic Partner — A person of the same sex with whom you have entered into a domestic partnership as defined under Chapter 246, P.L. 2003, the Domestic Partnership Act. Domestic partner health benefits coverage is only available to State employees/ retirees or to local government/education employees/retirees whose employers have adopted a resolution to provide Chapter 246 health benefits coverage. A photocopy of the *New Jersey Certificate of Domestic Partnership* dated prior to February 19, 2007 (or a valid certification from another State or foreign jurisdiction that recognizes same-sex domestic partners) and additional supporting documentation are required for enrollment. The cost of same-sex domestic partner coverage may be subject to federal tax (see your employer or Fact Sheet #71, *Benefits Under the Domestic Partnership Act,* for details).

Eligible Dependent — A member's spouse or same-sex domestic partner (as defined by Chapter 246, P.L. 2003) and child(ren) under the age of 26. Children include natural, adopted, foster, and stepchildren. If a covered child is not capable of self-support when (s)he reaches age 26 due to mental illness, mental retardation, or a physical disability, coverage under the SHBP may be continued (see page 3).

Employer — The State, or a local public employer which participates in the State Health Benefits Program.

Endodontics — Concerned with the biology and pathology of the dental pulp and surrounding tissues. Root canal treatment.

Gingivectomy — Removal of gum tissue.

Gingivoplasty — A surgical procedure that reshapes and recontours the gum tissue in order to attain functional form.

Inlay — A cast metallic or ceramic filling for a dental cavity.

Local Employee — For purposes of SHBP coverage, a local employee is a full-time employee receiving a salary and working for a Participating Local Employer. Full-time shall mean employment of an eligible employee who appears on a regular payroll and who receives salary or wages for an average number of hours specified by the employer, but not to be less than 25 hours per week or more if required by contract. It also means employment in all 12 months of the year except in the case of those employees engaged in activities where the normal work schedule is 10 months. In addition, for local coverage, employee shall also mean an appointed or elected officer of the local employer, including an employee who is compensated on a fee basis as a convenient method of payment of wages or salary but who is not a self-employed independent contractor compensated in a like manner. To qualify for coverage as an appointed officer, a person must be appointed to an office specifically established by

law, ordinance, resolution, or such other official action required by law for establishment of a public office by an appointing authority. A person appointed under a general authorization, such as to appoint officers or to appoint such other officers or similar language is not eligible to participate in the program as an appointed officer. An officer appointed under a general authorization must qualify for participation as a full-time employee.

Local Employer — Government employers in New Jersey, including counties, municipalities, townships, school districts, community colleges, and various public agencies or organizations.

Mandibular — Relating to the lower jaw.

Maxillary — Relating to the upper jaw.

Member — With respect to the Employee Dental Plans, employees eligible to enroll in the State Health Benefits Program and their dependents including a spouse or eligible same-sex domestic partner.

Myofunctional — Relating to the role of muscle function in the correction of oral problems.

Onlay — A type of metal or ceramic restoration that overlays the tooth to provide additional strength to that tooth.

Orthodontic — Concerned with the correction and prevention of irregularities of the teeth. Dental orthopedics.

Osteoplasty — Resection of the bony structure to achieve acceptable gum contour.

Palliative Treatment — Alleviation of symptoms without curing the underlying disease.

Periodontics — Concerned with the treatment of abnormal conditions and diseases of the tissues that surround and support the teeth.

Pontic — An artificial tooth on a fixed partial denture.

Prophylaxis — A series of procedures whereby calculus (calcified deposits), stain, and other accretions are removed from the clinical crowns of the teeth and the enameled surfaces are polished.

Prosthodontics — The science of and art of providing suitable substitutes for crowns of teeth, or for replacing lost or missing teeth.

Pulpotomy — Removal of a portion of the pulp structure of a tooth, usually the coronal portion.

Reasonable and Customary — A charge by a dentist, or by any other provider of services or supplies, that does not exceed the prevailing charge for the same service or supply made by similar providers in the same geographic area. The member is responsible for any amount a dentist or provider charges above the reasonable and customary allowance.

Resin — A material used in dental restoration.

Scaling and Root Planing — The removal of subgingival calcified deposits around the teeth and the cleaning of the gingival pocket.

School Employees' Health Benefits Commission — The entity created by N.J.S.A. 52:14-17.46 and charged with the responsibility of overseeing the School Employee's Health Benefits Program.

School Employees' Health Benefits Program (SEHBP) — The SEHBP was established by Chapter 103, P.L. 2007. It offers medical and prescription drug coverage to qualified school employees and retirees, and their eligible dependents. Local employers must adopt a resolution to participate in the SEHBP. The School Employees' Health Benefits Program Act is found in the N.J.S.A. 52:14-17.46 et seq. Rules governing the operation and administration of the program are found in Title 17, Chapter 9 of the New Jersey Administrative Code.

SEHBP Member — An individual who is either a School Employees' Health Benefits Program Active Group, Retired Group, or COBRA participant and their dependents.

SHBP Member — An individual who is either a State Health Benefits Program Active Group, Retired Group, or COBRA participant and their dependents.

State Biweekly Employee — For health benefits purposes, state biweekly employee means a full-time employee of the State, or an appointed or elected officer, paid by the State's centralized payroll system whose benefits are based on a biweekly cycle. Full-time requires 35 hours per week or more if required by contract.

State Health Benefits Commission (Commission) — The entity created by N.J.S.A. 52:14-17.27 and charged with the responsibility of establishing and overseeing the State Health Benefits Program.

State Health Benefits Program (SHBP) — The SHBP was originally established by statute in 1961. It offers medical, prescription drug, and dental coverage to qualified public employees and retirees, and their eligible dependents. Local employers must adopt a resolution to participate in the SHBP and its plans. The State Health Benefits Program Act is found in the N.J.S.A. 52:14-17.25 et seq. Rules governing the operation and administration of the program are found in Title 17, Chapter 9 of the New Jersey Administrative Code.

State Monthly Employee — For purposes of SHBP coverage, state monthly employee shall mean a full-time employee of the State, or an appointed or elected officer, whose benefits are based on a monthly cycle and whose payroll system is autonomous (not paid by the State's centralized payroll system). Full-time requires 35 hours per week or more if required by contract.

State Monthly Employer — Employers whose benefits are based on a monthly cycle and whose payroll system is autonomous (not paid by the State's centralized payroll system). This includes state colleges and universities and participating independent state commissions, authorities, and agencies such as:

- Rutgers, the State University of New Jersey
- Palisades Interstate Park Commission
- New Jersey Institute of Technology
- University of Medicine and Dentistry of NJ

- Thomas A. Edison State College
- William Paterson University
- Ramapo State College
- Rowan University
- The College of New Jersey
- Montclair State University
- New Jersey City University
- Kean University
- Stockton State College
- New Jersey State Library
- New Jersey State Legislature and legislative offices
- New Jersey Building Authority
- New Jersey Commerce and Economic Growth Commission
- Waterfront Commission of New York Harbor
- Agencies or special projects that are supported from, or whose employees are paid from, sources of revenue other than general funds, which other funds shall bear the cost of benefits under this program.

Temporo-mandibular — Denoting the joint of the lower jaw.

APPENDIX III

AVAILABLE DENTAL PLANS

UNIT/ DPO #	PLAN NAME	MEMBER SERVICES	2011 PLAN YEAR SERVICE AREAS*
301	**BeneCare** (Atlantic Southern Dental Foundation)	1-800-843-4727 *www.benecare.com*	All of New Jersey (Except Hunterdon, Morris, Passaic, Salem, Somerset, Sussex & Warren Counties)
302	**Community Dental Associates**	(856) 451-8844 *www.cdaplan.com*	Cumberland County
305	**CIGNA Dental Health, Inc.**	1-800-367-1037 *www.cigna.com/stateofnj*	All of New Jersey (Except Cape May County); Eastern Pennsylvania
307	**Healthplex** (International Health Care Services)	1-800-468-0600 *www.healthplex.com*	All of New Jersey (Except Cape May, Glouster, Hunterdon, Salem, Sussex & Warren Counties); Bucks County and Philadelphia, Pennsylvania
317	**Horizon Dental Choice**	1-800-433-6825 *www.horizonblue.com*	All of New Jersey (Except Salem County)
319	**Aetna DMO**	1-800-843-3661 *www.aetna.com/statenj*	All of New Jersey, Eastern Pennsylvania
399	**Dental Expense Plan** (Administered by Aetna)	1-877-238-6200 *www.aetna.com/statenj*	Unrestricted

*If a county is listed as not served, there are an insufficient number of dental providers within the county for the respective DPO network. For information about DPO dental providers within a covered area of service, contact the DPO directly.

APPENDIX IV

TAX$AVE FOR STATE EMPLOYEES

Tax$ave is a benefit program defined by Section 125 of the federal Internal Revenue Code that allows eligible New Jersey State employees to use pre-tax dollars to pay for qualified medical, dental, and dependent care expenses and thereby increase their take-home pay. The pre-tax deduction effectively reduces the salary on which taxes are computed by the amount of the health, dental, or dependent care deduction.

Tax$ave consists of three components:

- The **Premium Option Plan** (POP) allows eligible New Jersey State employees to make payments for basic health and dental plan premiums on a pre-tax basis and thereby increase their take-home pay. Any increase in take-home pay will depend on the health and/ or dental plan selected and the level of coverage (single, member and spouse, parent and child(ren) or family).
- The **Unreimbursed Medical Flexible Spending Account** (FSA) allows eligible New Jersey State employees to set aside money to pay for qualified medical and dental expenses not paid by any group benefits plan under which they or their dependents are covered (see limitations on civil union partners and same-sex domestic partners, on page 43).
- The **Dependent Care Flexible Spending Account Plan** (FSA) allows an eligible New Jersey State employee to set aside funds to pay for anticipated expenses related to dependent care required to permit the employee and spouse to work.

  The Tax$ave FSAs are administered for the Division of Pensions and Benefits by the Fringe Benefits Management Company (FBMC). Employees can enroll in Tax$ave when first hired or annually each fall during the Tax$ave Open Enrollment period (see below).

Fact Sheet #44, *Tax$ave,* outlines the Tax$ave Program and may be obtained from your benefits administrator or from the Division of Pensions and Benefits. You can also visit the Division's' Tax$ave Internet page at: *www.state.nj.us/treasury/pensions/taxsave.shtml*

Note: The *Tax$ave* program is <u>not</u> available to local employees. Contact your employer to find out if you are eligible to pay premiums on a pre-tax basis through an IRC Section 125 Program offered by your employer.

Tax$ave Open Enrollment

Enrollment in the POP is automatic unless you decline enrollment each year during the Tax$ave Open Enrollment.

You may enroll in, or make changes to, Tax$ave FSAs during the Tax$ave Open Enrollment by calling FBMC at 1-866-440-7150 or online at: *www.myFBMC.com*.

EFFECT OF POP PARTICIPATION ON SHBP RULES AND PROCEDURES

Your participation in the **Premium Option Plan** (POP) may effect your participation in the State Health Benefits Program.

As a State employee you are automatically enrolled in the POP and save on taxes for any health and/or dental premiums/contributions you pay through payroll deductions — unless you decline enrollment at the time you first become eligible for health and dental plan coverage or during the Tax$ave Open Enrollment period (see "Declining POP" below).

The Tax$ave Program is strictly regulated by the Internal Revenue Service (IRS) because of the tax advantages provided under the POP. IRS rules require that for an employee covered by the POP, payroll deductions for health and/or dental plan benefits remain the same for the entire plan year. Therefore, no coverage level changes can be made to your health and/or dental plan enrollment that would result in a change in the amount of your deduction unless a "Qualifying Event" has occurred. If a Qualifying Event does occur (see below), you may make a change by submitting a completed *Health Benefits Application* to your employer within 60 days of a Qualifying Event. Changes can also be made during the annual Tax$ave Open Enrollment period.

Qualifying Events:

- A marriage (employee may enroll spouse and any other eligible dependents — see page 43 for limitations on civil union partners and domestic partners).
- Addition of an eligible dependent due to birth, adoption, or legal guardianship.
- A change in family status involving the loss of eligibility of a family member (separation, divorce, death, child turns age 26).
- A move outside an HMO service area.
- The termination of a member's employment for any reason, including retirement.
- The taking of an approved unpaid leave of absence.
- A change in a spouse's or eligible dependent's employment status resulting in their loss of health and/or dental coverage.
- Such other events that may be determined to be appropriate and in accordance with applicable IRS regulations.

Declining POP

Since enrollment is automatic for employees with health or dental plan deductions, a newly hired employee who does not want to participate in the POP may decline participation by completing a *Declination of Premium Option Plan* form.

Leave Without Pay (LWOP)

A Tax$ave election in effect at the beginning of the plan year will continue until a change is made during the Tax$ave Open Enrollment period or upon the occurrence of a Qualifying Event. An employee who declined enrollment in the POP and is on leave during the Annual Open Enrollment Period may elect enrollment in the POP upon return to active employment.

CIVIL UNIONS, DOMESTIC PARTNERS, AND TAX$AVE

The Internal Revenue Service does not recognize a New Jersey civil union partner or same-sex domestic partner as a dependent for tax purposes in the same manner that it recognizes a spouse or dependent children of an employee. Therefore, your employer may have to treat a civil union partner or domestic partner SHBP benefit as federally taxable.

As a result, a civil union partner or domestic partner must be able to qualify as a "tax dependent" of the employee for federal tax filing purposes — under Internal Revenue Code Section 152 — before an out-of-pocket medical or dental expense incurred by the partner can be reimbursed under the Unreimbursed Medical Spending Account and before any premiums that the employee pays for the civil union partner or domestic partner coverage can be made on a pre-tax basis under the Premium Option Plan. See *IRS Tax Topic 354 - Dependents* for additional information on the requirements for establishing dependent status for federal tax purposes.

If the civil union partner or domestic partner is not a "qualified tax dependent" of the employee, the partner's SHBP coverage is considered federally taxable and the employee cannot be reimbursed under the Unreimbursed Medical Spending Account for any out-of-pocket medical or dental expense incurred by the partner, nor make pre-tax payments for the cost of the partner's coverage under the Premium Option Plan. (Pre-tax dollars may still be used to pay for the employee's portion of the cost of his or her own and dependent children's coverage.)

The civil union partner or domestic partner SHBP benefit is not subject to New Jersey State income tax. If you live outside of New Jersey, you should check with your State's tax agency to determine if the civil union partner or domestic partner SHBP benefit is subject to state taxes.

- Additional information about New Jersey Civil Unions can be found in Fact Sheet #75, *Civil Unions.*
- Additional information about the New Jersey Domestic Partnership Act can be found in Fact Sheet #71, *Benefits Under the Domestic Partnership Act.*

See page 50 for information on how to obtain these publications.

APPENDIX V

NOTICE OF PRIVACY PRACTICES TO ENROLLEES

State Health Benefits Program
School Employees' Health Benefits Program

This Notice describes how medical (and dental) information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

Protected Health Information

The State Health Benefits Program and School Employees' Health Benefits Program (Program) are required by the federal Health Insurance Portability and Accountability Act (HIPAA) and State laws to maintain the privacy of any information that is created or maintained by the programs that relates to your past, present, or future physical or mental health. This Protected Health Information (PHI) includes information communicated or maintained in any form. Examples of PHI are your name, address, Social Security number, birth date, telephone number, fax number, dates of health care service, diagnosis codes, and procedure codes. PHI is collected by the Program through various sources, such as enrollment forms, employers, health care providers, federal and State agencies, or third-party vendors.

The Program is required by law to abide by the terms of this Notice. The programs reserve the right to change the terms of this Notice. If material changes are made to this Notice, a revised Notice will be sent.

Uses and Disclosures of PHI

The Program is permitted to use and to disclose PHI in order for our members to obtain payment for health care services and to conduct the administrative activities needed to run the Program without specific member authorization. Under limited circumstances, we may be able to provide PHI for the health care operations of providers and health plans. Specific examples of the ways in which PHI may be used and disclosed are provided below. This list is illustrative only and not every use and disclosure in a category is listed.

- The Program may disclose PHI to a doctor or a hospital to assist them in providing a member with treatment.
- The Program may use and disclose member PHI so that our Business Associates may pay claims from doctors, hospitals, and other providers.
- The Program receives PHI from employers, including the member's name, address, Social Security number, and birth date. This enrollment information is provided to our Business Associates so that they may provide coverage for health care benefits to eligible members.

- The Program and/or our Business Associates may use and disclose PHI to investigate a complaint or process an appeal by a member.
- The Program may provide PHI to a provider, a health care facility, or a health plan that is not our Business Associate that contacts us with questions regarding the member's health care coverage.
- The Program may use PHI to bill the member for the appropriate premiums and reconcile billings we receive from our Business Associates.
- The Program may use and disclose PHI for fraud and abuse detection.
- The Program may allow use of PHI by our Business Associates to identify and contact our members for activities relating to improving health or reducing health care costs, such as information about disease management programs or about health-related benefits and services or about treatment alternatives that may be of interest to them.
- In the event that a member is involved in a lawsuit or other judicial proceeding, the Program may use and disclose PHI in response to a court or administrative order as provided by law.
- The Program may use or disclose PHI to help evaluate the performance of our health plans. Any such disclosure would include restrictions for any other use of the information other than for the intended purpose.
- The Program may use PHI in order to conduct an analysis of our claims data. This information may be shared with internal departments such as auditing or it may be shared with our Business Associates, such as our actuaries.

Except as described above, unless a member specifically authorizes us to do so, the Program will provide access to PHI only to the member, the member's authorized representative, and those organizations who need the information to aid the Program in the conduct of its business (our "Business Associates"). An authorization form may be obtained over the Internet at: *www.state.nj.us/treasury/pensions* or by sending an e-mail to: *hipaaform@treas.state.nj.us.* A member may revoke an authorization at any time.

Restricted Uses

- PHI that contains genetic information is prohibited from use or disclosure by the Programs for underwriting purposes.
- The use or disclosure of PHI that includes psychotherapy notes requires authorization from the member.

When using or disclosing PHI, the Program will make every reasonable effort to limit the use or disclosure of that information to the minimum extent necessary to accomplish the intended purpose. The Program maintains physical, technical and procedural safeguards that comply with federal law regarding PHI. In the event of a breach of unsecured PHI the member will be notified.

Member Rights

Members of the Program have the following rights regarding their PHI.

Right to Inspect and Copy: With limited exceptions, members have the right to inspect and/or obtain a copy of their PHI that the Program maintains in a designated record set which consists of all documentation relating to member enrollment and the Program's use of this PHI for claims resolution. The member must make a request in writing to obtain access to their PHI. The member may use the contact information found at the end of this Notice to obtain a form to request access.

Right to Amend: Members have the right to request that the Program amend the PHI that we have created and that is maintained in our designated record set.

We cannot amend demographic information, treatment records or any other information created by others. If members would like to amend any of their demographic information, please contact your personnel office. To amend treatment records, a member must contact the treating physician, facility, or other provider that created and/or maintains these records.

The Program may deny the member's request if: 1) we did not create the information requested on the amendment; 2) the information is not part of the designated record set maintained by the Program; 3) the member does not have access rights to the information; or 4) we believe the information is accurate and complete. If we deny the member's request, we will provide a written explanation for the denial and the member's rights regarding the denial.

Right to an Accounting of Disclosures*:* Members have the right to receive an accounting of the instances in which the Program or our Business Associates have disclosed member PHI. The accounting will review disclosures made over the past six years or back to April 14, 2003, whichever period is shorter. We will provide the member with the date on which we made a disclosure, the name of the person or entity to whom we disclosed the PHI, a description of the information we disclosed, the reason for the disclosure, and certain other information. Certain disclosures are exempted from this requirement (e.g., those made for treatment, payment or health benefits operation purposes or made in accordance with an authorization) and will not appear on the accounting.

Right to Request Restrictions: The member has the right to request that the Program place restrictions on the use or disclosure of their PHI for treatment, payment, or health care operations purposes. The Program is not required to agree to any restrictions and in some cases will be prohibited from agreeing to them. However, if we do agree to a restriction, our agreement will always be in writing and signed by the Privacy Officer. The member request for restrictions must be in writing. A form can be obtained by using the contact information found at the end of this Notice.

Right to Restrict Disclosure: The member has the right to request that a provider restrict disclosure of PHI to the Programs or Business Associates if the PHI relates to services or a health care item for which the individual has paid the provider in full. If payment involves a flexible spending account or health savings account, the individual cannot restrict disclosure of information necessary to make the payment but may request that disclosure not be made to another program or health plan.

Right to Receive Notification of a Breach: The member has the right to receive notification in the event that the Programs or a Business Associate discover unauthorized access or release of PHI through a security breach.

Right to Request Confidential Communications: The member has the right to request that the Program communicate with them in confidence about their PHI by using alternative means or an alternative location if the disclosure of all or part of that information to another person could endanger them. We will accommodate such a request if it is reasonable, if the request specifies the alternative means or locations, and if it continues to permit the Program to collect premiums and pay claims under the health plan.

To request changes to confidential communications, the member must make their request in writing, and must clearly state that the information could endanger them if it is not communicated in confidence as they requested.

Right to Receive a Paper Copy of the Notice: Members are entitled to receive a paper copy of this Notice. Please contact us using the information at the end of this Notice.

Questions and Complaints

If you have questions or concerns, please contact the Program using the information listed at the end of this Notice. (Local county, municipal, and Board of Education employees should contact the HIPAA Privacy Officer for their employer.)

If members think the Program may have violated their privacy rights, or they disagree with a decision made about access to their PHI, in response to a request made to amend or restrict the use or disclosure of their information, or to have the Program communicate with them in confidence by alternative means or at an alternative location, they must submit their complaint in writing. To obtain a form for submitting a complaint, use the contact information found at the end of this Notice.

Members also may submit a written complaint to the U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201.

The Program supports member rights to protect the privacy of PHI. It is your right to file a complaint with the Program or with the U.S. Department of Health and Human Services.

Contact Office:	The Division of Pensions and Benefits HIPAA Privacy Officer
Address:	Division of Pensions and Benefits Bureau of Policy and Planning PO Box 295 Trenton, NJ 08625-0295
E-mail:	*hipaaform@treas.state.nj.us*

HEALTH BENEFITS CONTACT INFORMATION

ADDRESSES

Our Mailing Address is . . . . . Division of Pensions and Benefits
Health Benefits Bureau
PO Box 299
Trenton, NJ 08625-0299

Our Internet Address is . . . . . *www.state.nj.us/treasury/pensions/health-benefits.shtml*

Our E-mail Address is . . . . . *pensions.nj@treas.state.nj.us*

TELEPHONE NUMBERS

Division of Pensions and Benefits:

Office of Client Services . . . . . (609) 292-7524

TDD Phone (Hearing Impaired) . . . . . (609) 292-7718

Dental Plan Organizations

Aetna DMO 1-800-843-3661

BeneCare (Atantic Southern Dental Foundation) 1-800-843-4727

CIGNA Dental Health, Inc. 1-800-367-1037

Community Dental Associates . . . . . (856) 451-8844

Healthplex (International Health Care Services) 1-800-468-0600

Horizon Dental Choice 1-800-433-6825

Dental Expense Plan — Aetna Dental 1-877-238-6200

RELATED HEALTH SERVICES

State Employee Advisory Service (EAS) 24 hours a day 1-866-EAS-9133

New Jersey State Police
Employee Advisory Program (EAP) 1-800-FOR-NJSP

Rutgers University Personnel Counseling Service
Employee Advisory Program (EAP) . . . . . (732) 932-7539

University of Medicine and Dentistry of New Jersey
Employee Advisory Program (EAP) . . . . . (973) 972-5429

New Jersey Department of Banking and Insurance

Individual Health Coverage Program Board	1-800-838-0935
Consumer Assistance for Health Insurance	(609) 292-5316 (Press 2)

New Jersey Department of Human Services

Pharmaceutical Assistance to the Aged and Disabled (PAAD)	1-800-792-9745

New Jersey Department of Health and Senior Services

Division of Aging and Community Services	1-800-792-8820
Insurance Counseling	1-800-792-8820
Independent Health Care Appeals Program	(609) 633-0660

Centers for Medicare and Medicaid Services

Medicare Part A and Part B	1-800-MEDICARE

HEALTH BENEFITS PUBLICATIONS

The publications and fact sheets available from the Division of Pensions and Benefits provide information on a variety of subjects. Fact sheets, handbooks, applications, and other publications are available over the Internet at: *www.state.nj.us/treasury/pensions*

General Publications

Summary Program Description — An overview of SHBP/SEHBP eligibility and plans

Plan Comparison Summary — Out-of-pocket cost comparison charts for State employees, local government employees, local education employees, and all retirees

Health Benefit Fact Sheets

Fact Sheet #11, *Enrolling in the Health Benefits Coverage When you Retire*

Fact Sheet #23, *Health Benefits and Medicare Parts A & B for Retirees*

Fact Sheet #25, *Employer Responsibilities under COBRA*

Fact Sheet #26, *Health Benefits Options upon Termination of Employment*

Fact Sheet #30, *The Continuation of Health Benefits Coverage under COBRA*

Fact Sheet #37, *Employee Dental Plans*

Fact Sheet #47, *Retired Health Benefits Coverage under Chapter 330 - PFRS & LEO*

Fact Sheet #51, *Continuing Health Benefits Coverage for Over Age Children with Disabilities*

Fact Sheet #60, *Voluntary Furlough Program*

Fact Sheet #66, *Health Benefits Coverage for Part-Time Employees*

Fact Sheet #69, *SHBP Coverage for State Intermittent Employees*

Fact Sheet #71, *Benefits under the Domestic Partnership Act*

Fact Sheet #73, *Retiree Dental Expense Plan*

Fact Sheet #74, *Health Benefits Coverage of Children until Age 31 under Ch. 375, P.L. 2007*

Fact Sheet #75, *Civil Unions*

Health Plan Member Handbooks

Aetna Freedom PPO and Value HD Plans Member Handbook

NJ DIRECT Member Handbook

Aetna HMO Member Handbook

Horizon HMO Member Handbook

Prescription Drug Plans Member Handbook

Employee Dental Plans Member Handbook

Retiree Dental Expense Plan Member Handbook

BLANK PAGE

HD-0379-0513